Anthem BlueCross BlueShield

STATE OF WISCONSIN DENTALBLUE CONTINUATION FORM

Employee Name	Applicant Name (if different from employee name)
Applicant Address (Street, City, State, Zip)	Applicant Phone Number
Applicant Social Security Number	Applicant DentalBlue Member ID Number (if known)

Section 1: Reason Continuation Elected (qualifying event)

☐ End of employment – enter employment end date: _____
☐ Retirement (indefinite continuation) – enter retirement date: _____
☐ Divorce/end of domestic partnership – enter event date: _____
☐ Dependent no longer eligible – enter event date: _____
☐ Other* (explain): such as disability applied for _____

*If the person electing continuation is not the subscriber, include a group DentalBlue Application with this Form

Section 2: Coverage to Be Continued (check one below)

☐ Single coverage ☐ Two-Person coverage ☐ Family coverage (3 or more insured)

Complete the following information **ONLY** for individuals covered under this policy you plan to continue

Last Name	First Name	Birth Date	Gender	Relationship
			M F	
			M F	
			M F	
			M F	
			M F	

Select the one plan you would like to continue: ☐ DentaCare HMO ☐ Preferred PPO ☐ Supplemental Plan

*NOTE: You are only eligible to continue the plan you are currently enrolled in, until Open Enrollment. However, if you carry the Supplemental Plan, you must carry a minimum of Preventative and Diagnostic dental coverage through another plan. If you do not have this primary dental coverage then you must elect to continue the HMO or the PPO plan.

Section 3: Signature of Applicant – date and sign continuation form below:

Date (Mo/Day/Yr)	Applicant Signature:

Do not include any money with this application. Anthem DentalBlue will bill you directly on a monthly or quarterly basis, depending on your status as a Cobra continuant or retiree. Send this form (and application if appropriate) to:

Anthem DentalBlue
4361 Irwin Simpson Rd | Mason, OH 45040

For Employer Use Only

The individual(s) losing coverage is / is not eligible to continue coverage. If not eligible, it is due to:
☐ Failure to notify the employer within 60 days of loss of eligibility
☐ Other (explain):

Extension of group coverage is in compliance with: ☐ COBRA ☐ Retiree Continuation ☐ Domestic Partner Continuation

Group Premium Paid Though: | Group Number (check one): ☐ 83445 ☐ 93881

Monthly Premium Amount Due for Continuad Coverage: $_____
Note: If you change your coverage level when you continue coverage, your premium may be different than the amount shown here.
Note: Coverage level can only be decreased at time of Continuation without a qualifying event, or until Open Enrollment

Anthem DentalBlue Continuation Form - State of Wisconsin (Rev 6/2012)